PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	PLETED
		15G190	B. WING			1/2012
)	DOLUBER OF SUMP			ET ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF I	PROVIDER OR SUPPLIE	R	120 Å	AVENUE C		
	NORTHWEST IND		GRIF	FITH, IN 46319		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	· ·		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W0000						
			W0000			
		1	W 0000			
		predetermined full				
	recertification ar	nd state licensure survey				
	This survey was	done in conjunction with				
	the post certifica	ntion revisit to the				
	investigation of	complaint #IN00104522.				
	Dates of Survey	: May 9, 10 and 11, 2012.				
	Facility number:	000722				
	Provider number					
	AIM number: 2					
	Anvi number. 2	00234370				
	Common Clari	istina Calan Madical				
	_	istine Colon, Medical				
	Surveyor III/QN	IRP				
	The fellers 1	afiaianaiaa alaa				
	_	eficiencies also reflect				
	_	accordance with 460 IAC				
	9.					
		was completed on				
	5/22/12 by Tim	Shebel, Medical Surveyor				
	III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G190	B. WIN			05/11/2012	
NAME OF B	AD CAMPED OF GUIDNI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	-		120 AV	ENUE C		
	NORTHWEST INDI			GRIFFI	TH, IN 46319		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0114	483.410(c)(4) CLIENT RECOR Any individual wholient's record mand sign it. Based on record facility 1. failed to dated Behavior S. Individual Supposampled clients (to ensure entries legible for 2 of 2 #1 and #2). Findings include A review of client conducted at the at 10:00 A.M Find the dated 8/11-8/12 find guardian or Servisignature. Review of Signature. An interview with on 5/11/12 at 11: indicated the BSI been signed. No was available for	IDS no makes an entry in a just make it legibly, date it, review and interview the to have a signed and support Plan (BSP) and port Plan (ISP) for 1 of 2 delient #1) and 2. failed made in records were sampled clients (clients) It #1's record was group home on 5/11/12 Review of client #1's BSP failed to have a client, ice Coordinator (SC) wo of client #1's ISP dated have a client, guardian In the SC was conducted 15 A.M The SC P and ISP should have further documentation review to indicate client P had a client, guardian	Wo	114	Service Coordinator will make sure all documents are clearly and properly signed. To ensure future compliance, Service Coordinator will audit files annually and thereafter.		DATE 06/10/2012

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Event ID: LZY011

Facility ID: 000722

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	OF CORRECTION	DENTIFICATION NUMBER: 15G190	A. BUILDING B. WING	00	COMPLETED 05/11/2012
	PROVIDER OR SUPPLIER	NA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CODE 'ENUE C ITH, IN 46319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR L 2. Client #1's med reviewed on 5/11/ including entries be Care Physician (Pedient #1's PCP well and the Client #2's medical on 5/11/12 at 10:5 entries by client #2's PCP an interview with Nurse (LPN) was 11:50 A.M The I entries made by client #2 and the Client #2	lical records were 12 at 10:00 A.M., by client #1's Primary CP). Entries made by ere not legible. 1 records were reviewed 0 A.M., including 2's PCP. Entries made were not legible. the Licensed Practical conducted on 5/11/12 at		CROSS-REFERENCED TO THE APPROPRIA	ATE

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Event ID: LZY011

Facility ID: 000722

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE			ETED	
		15G190	B. WIN			05/11/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			120 AV	ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0183	on duty and awa clients are prese appropriate actio fire or other eme residential living (i) Clients for w a medical care p (ii) Clients who security risks; (iii) More than 1	esponsible direct care staff ke on a 24-hour basis, when nt, to take prompt, on in case of injury, illness, rgency, in each defined unit housing: hom a physician has ordered lan; are aggressive, assaultive or					
	facility failed for (client #1) and 1 #3), to assure aw and on duty for a time period from potentially affect the group home, #4). Findings include A review of client conducted on 5/1 Review of client Individual Suppose 8/15/11 indicated programming include	ew and record review, the of 1 of 2 sampled clients additional client (client take staff were present all overnight shifts for the 14/1/12- to 5/11/12. This is all clients who lived at (clients #1, #2, #3 and the staff were present at 1/12 at 10:00 A.M #1's most current tort Plan (ISP) dated the staff were present at 1/12 at 10:00 A.M #1's most current tort Plan (ISP) dated the staff were present which is the staff were present to the staff were present with the staff was a staff with the staff were present with the staff was a staff was a staff was a staff with the staff was a staff with the staff was a staff was	WO	183	Adequate staffing was provide 6/8/12Client #1 has not had ar type of physical or verbal aggression in a year and Clien #3 has only had 3 aggressive gestures towards staff and no physical aggression and only clincident of head banging in a year. None of these incidents have occurred during the overnight period. Therefore adequate staffing was provided To ensure future compliance a proper staffing, Service Coordinator will audit tracking sheets monthly and logs daily any behavioral changes that moccur.CorrectionW183 Overnight staffing is being implemented at AVE C, and wide begin on 6/18/12.	ny it one d. ind for nay	06/10/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15G190	B. WIN			05/11/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ENUE C		
ARC OF	NORTHWEST IND				TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Disorder Sympto	oms." Review of client					
	#1's "Positive Be	ehavioral Support Plan"					
	dated 8/11-8/12	indicated: "Targeted					
	behavior - Physical						
	AggressionMedication Considerations:						
	Abilify 10 mg in the morning for the						
	clinical impression of Impulse Control Disorder."						
	2 1501 401.						
	A review of clies	nt #3's record was					
	conducted on 5/11/12 at 11:00 A.M Review of client #3's most current						
		ort Plan (ISP) dated					
		"On a behavior plan for					
		propriate behaviors."					
	Review of client	#3's Behavioral Support					
	Plan (BSP) dated	d 8/11-8/12 indicated:					
	"Targeted behav	ior - Banging head."					
		actual hours worked,					
	,	f schedule was conducted					
	1	dministrative office on					
	5/11/12 at 10:00	A.M Review of the					
	group home staf	f schedules indicated no					
	awake staff were	e present and on duty on					
	4/1/12 through 5	-					
	An interview wi	th the Area Manager					
		icted at the facility's					
	` ′	ffice on 5/11/12 at 11:30					
		indicated the group home					
		rnight awake staff					
		AM further indicated					
	there was overni	ght asleep staff at this					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 1/2012
NAME OF F	PROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP (CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		TH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	group home. No was available for	o further documentation r review to indicate there available and on duty for		CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	15G190	A. BUILDING	00	COMPLETED 05/11/2012
		190 190	B. WING		
NAME OF I	PROVIDER OR SUPPLIEF	1		ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		'ENUE C ITH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE COM ESTIBLE
TAG W0189	483.430(e)(1)	LISC IDENTIFYING INFORMATION)	TAG	DEFICIENC1)	DATE
WU 109	STAFF TRAININ The facility must initial and contin employee to pe	IG PROGRAM provide each employee with uing training that enables the form his or her duties ently, and competently.	W0189	Service Coordinator will tra	ain all 06/10/2012
	Based on record	review and interview the		DSPs working at the group ho	
		4 of 4 clients residing at		on ISP, BSP and Risk Platensure future compliance,	
	the group (client	s #1, #2, #3 and #4) to		DSPs will be train on ISP,	
	provide staff wit	h initial and ongoing		and Risk Plans before wor	
	training on each	clients' Individual		the group home. 6/8/12 Service Coordinator will re	train
	L'unnort Diona (IVD) Diale Diona and	staff currently working at the			
	Behavior Suppor	rt Plans (BSP).		group home on each indiv	
	Findings include: A review of the group home staff and client list was conducted on 5/9/12 at 2:15 P.M Review of the list indicated Direct Support Professionals (DSP) #1 and #2 were the only two staff who worked at the group home with clients #1, #2, #3 and #4. A request for the staff who worked at the group home with clients #1, #2, #3 and #4 was made on 5/11/12 at 9:45 A.M DSP #1 and #2's employee records were the only records submitted for review.	::		client. New staff will be tra foundations the week prior working this includes abus	to e and
		onducted on 5/9/12 at 2:15 If the list indicated Direct onals (DSP) #1 and #2 To staff who worked at the		neglect, med administration risk plans and behavioral supports; Service Coordinand Community Services I will train new staff on each individual client before worthe group home. To ensure future compliant Service Coordinator and Community Services Nurs	ator Nurse I rking at
		n clients #1, #2, #3 and #4 1/12 at 9:45 A.M DSP loyee records were the mitted for review.		train all new staff at the en foundations and all staff an and/or as needed.	
A review of the actual hours worked, group home staff clock in and out recor was conducted at the facility's administrative office on 5/11/12 at 10:0		f clock in and out record t the facility's			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		15G190	B. WING			05/11/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL BAJECT IND	IANA INO THE			ENUE C		
	NORTHWEST INDI	IANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
		f the group home staff					
	schedules indicated DSP #1, #2 and 6						
		vorked with clients #1,					
	#2, #3 and #4 from 4/1/12 through 5/11/12.						
	A man = = 1 C +	CC +::					
		ff training records was					
		at 10:15 A.M The					
		ator (SC) submitted					
	documentation which indicated only DSP #1 and #2 were trained on each clients'						
	· ·	and BSP. When asked if					
		entation available for					
		te DSP #3, #4, #5, #6, #7					
		ned on clients #1, #2, #3					
		n needs and training					
	programs, she sta						
		vas available for review					
		iff who worked at the					
		n clients #1, #2, #3 and #4					
		each clients program					
	needs.						
		, //11 1					
		nt #1's record was					
		1/12 at 10:00 A.M					
		#1's most current					
		ort Plan (ISP) dated					
		d "receives behavioral					
		cluding psychotropic					
		ing from Impulse Control					
		oms." Review of client					
		ehavioral Support Plan"					
		indicated: "Targeted					
	behavior - Physic	cal 					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN			05/11/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					ENUE C	
	NORTHWEST INDI	·		GRIFFI	TH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	CROSS-REFERENCE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		dication Considerations:		IAG		DATE
	Abilify 10 mg in the morning for the clinical impression of Impulse Control					
	_	ner review of client #1's				
		she had a personalized				
		Hearing Loss Risk Plan"				
	and a "History of	•				
	and a mistory of	i solegio i igii.				
	A review of clier	nt #2's record was				
		1/12 at 10:50 A.M				
	Review of client #2's record indicated an					
	ISP dated 2/14/11 which indicated:					
		history of Tuberculosis,				
		r, Tourettes and is non				
	1	review of the record				
		d a personalized "Haldol				
	Plan" and a "Yas	•				
	A review of clier	nt #3's record was				
	conducted on 5/1	1/12 at 11:00 A.M				
	Review of client	#3's most current				
	Individual Suppo	ort Plan (ISP) dated				
		"On a behavior plan for				
		ropriate behaviors."				
		#3's Behavioral Support				
	Plan (BSP) dated	1 8/11-8/12 indicated:				
	"Targeted behav	ior - Banging head."				
	Further review o	f client #3's record				
	indicated she had	d a personalized "High				
	Blood Pressure F	Plan" and a "Over Active				
	Bladder Plan."					
	A review of clier	nt #4's record was				
	conducted on 5/1	1/12 at 11:20 A.M				

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	of CORRECTION IDENTIFICATION NUMBER: 15G190	A. BUILDING B. WING	00	COMPLI 05/11/	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CO ENUE C TH, IN 46319	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	Review of client #4's most current Individual Support Plan (ISP) dated 11/11/11 indicated "Hypertension, Depression, Anxiety, Hearing loss and Diabetes Mellitus. Further review of the record indicated she had a personalized "Diabetic Plan" and a "Hearing Loss Risk Plan." An interview with the Area Manager (AM) and Service Coordinator (SC) was conducted at the facility's administrative office on 5/11/12 at 11:30 A.M The AM and SC both indicated the mentioned staff did not receive initial client specific training prior to working with clients #1, #2, #3 and #4. No documentation was submitted for review to indicate each staff received training on each clients training, behavioral and medical needs. 9-3-3(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G190	B. WIN			05/11/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	IANA INC, THE			ENUE C TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG W0268		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
WU208		VARD CLIENT nd procedures must promote elopment and independence	W0	268	Service Coordinator will train		06/10/2012
	facility failed for the group home (ation and interview, the 1 of 4 clients residing at (client #3), to promote of ensuring she was			DSPs on assisting client on #3 on shaving her facial hair. To ensure future compliance, Service Coordinator will monitor weekly for three months and bi-weekly thereafter.		
	Findings include	:					
	the group home of until 7:45 P.M	orvation was conducted at on 5/9/12 from 5:20 P.M. During the entire at #3, a female client, was a full facial hair.					
	conducted on 5/1 until 3:20 P.M	ogram observation was 10/12 from 2:00 P.M. During the entire at #3 was observed to air.					
	the group home of A.M. until 8:30 A observation clien have full facial h						
	An interview wit Coordinator (SC	th the Service) was conducted on					

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	OF CORRECTION OF CORRECTION 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 05/	TE SURVEY IPLETED 11/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP ENUE C TH, IN 46319	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	5/11/12 at 11:15 A.M The SC indicated the group home Direct Support Professional (DSP) staff are responsible for ensuring client #3 is prompted to shave. 9-3-5(a)				

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	FCORRECTION	IDENTIFICATION NUMBER: 15G190	A. BUILDING	00	COMPLETED	
		15G190	RECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		COMPLETED	
		100100			05/11/2012	
			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER		8		VENUE C		
ARC OF NORTHWEST INDIANA INC, THE			TITH, IN 46319			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
TAG W0388	REGULATORY OR 483.460(m)(1)(i) DRUG LABELIN Labeling for drug based on curren principles and pr	ation, record review, and cility failed for 1 of 2 (client #1), who received ave the medication pharmacy. Treation was conducted at on 5/11/12 from 6:00 A.M Client #1's e administered by Direct onal (DSP) #1 at 7:15 of Fluticasone al Spray (allergies) was t #1's medication box. of contain a pharmacy of stored in a container at #1's record was 11/12 at 10:00 A.M 2012, Physicians Orders			DATE 06/10/2012 ture	
	daily." An interview wi	th the Licensed Practical				

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G190	(X2) MULTIPLE CC A. BUILDING B. WING	00		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		120 AV	ADDRESS, CITY, STATE, ZIP (ENUE C TH, IN 46319	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Nurse (LPN) was conducted on 5/11/12 at 11:50 P.M The LPN indicated all medications should have a pharmacy label on them.				
	9-3-6(a)				

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IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f '		` ′	X3) DATE SURVEY	
OF CORRECTION		A. BUILDING B. WING				
	15G190			05/11/	2012	
NAME OF PROVIDER OR CURNITER			REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER		12	20 AVE	ENUE C		
ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		GF	RIFFIT	⁻ H, IN 46319		
			PROVIDER'S PLAN OF CORRECTION			(X5)
``				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
	LSC IDENTIFYING INFORMATION)	TA	\G			DATE
483.470(g)(2) SPACE AND EQ The facility must repair, and teach informed choices eyeglasses, hear communications devices identified as needed by the Based on observat interview, for 1 c wore eyeglasses failed to encoura wear her eye glass Findings include An evening obse the group home of until 7:45 P.M observation period her hearing aids. prompted by staff aids. A review of client exam dated 12/8/ hearing aids in be client #1's most of 7/15/11 indicated Review of client	puipment furnish, maintain in good a clients to use and to make a about the use of dentures, ring and other aids, braces, and other d by the interdisciplinary team e client. ation, record review and of 2 sampled clients who (client #1), the facility ge and teach client #1 to sses. : rvation was conducted at on 5/9/12 from 5:20 P.M. During the entire od client #2 was not if to wear her hearing at #1's record was 1/12 at 10:00 A.M #1's most current hearing /11 indicated she wore oth ears. Review of current physical dated if she wore hearing aids. #1's Individual Support	W0436		Service Coordinator will train DSPs on prompting client #1 to wear her eye glasses and heal aids, and client #2 to wear her hearing aid. To ensure future compliance, Service Coordinat will monitor weekly for three	o ring tor	DATE 06/10/2012
Plan dated 8/15/1	11 indicated client #1					
	ROVIDER OR SUPPLIER NORTHWEST INDI SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.470(g)(2) SPACE AND ECT The facility must repair, and teach informed choices eyeglasses, hear communications devices identified as needed by the Based on observation interview, for 1 ct wore eyeglasses failed to encourar wear her eye glasses fail	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview, for 1 of 2 sampled clients who wore eyeglasses (client #1), the facility failed to encourage and teach client #1 to wear her eye glasses. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.470(9)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. W0436 Based on observation, record review and interview, for 1 of 2 sampled clients who wore eyeglasses (client #1), the facility failed to encourage and teach client #1 to wear her eye glasses. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing aids. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M Review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current physical dated 7/15/11 indicated she wore hearing aids. Review of client #1's Individual Support Plan dated 8/15/11 indicated client #1	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROUTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. W0436 Based on observation, record review and interview, for 1 of 2 sampled clients who wore eyeglasses (client #1), the facility failed to encourage and teach client #1 to wear her eye glasses. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing aids. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M Review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current physical dated 7/15/11 indicated she wore hearing aids. Review of client #1's Individual Support Plan dated 8/15/11 indicated client #1	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the client. Based on observation, record review and interview, for 1 of 2 sampled clients who wore eyeglasses (client#1), the facility failed to encourage and teach client #1 to wear her eye glasses. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing aids. A review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current physical dated 7/15/11 indicated she wore hearing aids. Review of client #1's Individual Support Plan dated 8/15/11 indicated client #1 NO436 SERVICE COORDINATE, AND COMMENTATION NO436 Service Coordinator will train DSPs on prompting client #1 to wear her eye glasses and hea aids, and client #2 to wear her hearing aids. W0436 Service Coordinator will train DSPs on prompting client #1 to wear her hearing will monitor weekly for three months and bi-weekly thereaft. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M Review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids.	ROUTDER OR SUPPLIER ROUTDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) 483.470(g)(2) 58-vice Coordinator will train DSPs on prompting client #1 to wear her eye glasses and hearing aids, and client #2 to wear her hearing aid. To ensure future compliance, Service Coordinator will monitor weekly for three months and bi-weekly thereafter. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7-45 P.M During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing aids. A review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current physical dated 7/15/11 indicated she wore hearing aids. ROUTDIANA ROUTD

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G190	(X2) MULTIPLE CC A. BUILDING B. WING	00		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		120 AV	ADDRESS, CITY, STATE, ZIP (ENUE C TH, IN 46319	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 5/11/12 at 11:15 A.M The SC indicated client #1 wore hearing aids. When asked if staff should encourage and teach client #1 to wear her hearing aids, the SC stated "yes." 9-3-7(a)				

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AND PLAN OF CORRECTION 15G190 15G190	STATEMEN	(X3) DATE SURVEY	C		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX TAG REQUILATORY OR ISC IDENTIFYING INFORMATION) W0440 Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M The review failed to indicate the facility held an evacuation drills through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M The AM	AND PLAN	COMPLETED			
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0440 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3 and #4 on the evening shift during the second quarter (April 1st through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M The AM		05/11/2012	— I		
ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W0440 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M The review failed to indicate the facility held an evacuation drill stondard the evening shift during the second quarter (April 1st through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M The AM			CODE		
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SUMMARY STATEMENT OF DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTION (#AGLOGOSECTIVE ACTION SHOLLS BE PERFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (#AGLOGOSECTIVE ACTION SHOLLS BE GROSS-REFERRENCE) TO THE APPROPRIAL BEFORE THE ACTION SHOLLS BE GROSS-REFERRENCE TO THE APPROPRIAL BEFORE THE ACTION SHOLLS BEFORE T	ARC OF NORTHWEST INDIANA INC, THE				
PREFIX TAG W0440 Area Manager will train staff or conducting evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3 and #4 on the evening shift during the second quarter (April 1st through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M The AM			GRIFFITH, IN 46319		
PREFIX TAG	(X4) ID	(X5)	RRECTION		
W0440 W0440 W0440 W0440 W0440 W0440 W0440 W0440 W0440 W0440 Area Manager will train staff or conducting evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3 and #4 on the evening shift during the second quarter (April 1st through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M The AM	PREFIX	COMPLETION	SHOULD BE CO		
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during each quarter for each shift. The AM further indicated there was no documentation available for review to indicate a drill was conducted for the	TAG	DATE 06/10/2012 ure	n staff on n drills at nsure futu nager will		

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